Sutter Surgical Hospital – North Valley
A Sutter Health Affiliate
With You. For Life.

STATEMENT OF FINANCIAL CONDITION (Attachment A)

PATIENT NAME _____ SPOUSE _____
ADDRESS _____ PHONE _____
ACCOUNT # _____ SSN _____ _____
(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents that you support

Name	Age	Relationship

EMPLOYMENT AND OCCUPATION
Employer: _____ Position: _____
Contact Person & Telephone: _____
If Self-Employed, Name of Business: _____

Spouse Employer: _____ Position: _____
Contact Person & Telephone: _____
If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME

		Patient	Spouse
	Gross Pay (before deductions)		
Add:	Income from Operating Business (if Self-Employed)		
Add:	Other Income:		
	Interest and Dividends		
	From Real Estate or Personal Property		
	Social Security		
	Other (specify)		
	Alimony or Support Payments Received		
Subtract:	Alimony, Support Payments Paid		
Equals:	Current Monthly Income		
	Total Current Monthly Income (add Patient+Spouse Income from above)		

FAMILY SIZE
Total Family Members (add patient, spouse and dependents from above) _____

By signing this form, I agree to allow Sutter Surgical Hospital – North Valley to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I may be required to provide proof of the information I am providing.

_____ _____
Signature of Patient or Guarantor Date

_____ _____
Signature of Spouse Date

Sutter Surgical Hospital – North Valley
A Sutter Health Affiliate
With You. For Life.

NOTIFICATION FORM
SUTTER SURGICAL HOSPITAL – NORTH VALLEY
ELIGIBILITY DETERMINATION FOR CHARITY CARE

Sutter Surgical Hospital – North Valley has conducted an eligibility determination for charity care for:

PATIENT'S NAME	ACCOUNT NUMBER	DATE(S) OF SERVICE

The request for charity care was made by the patient or on behalf of the patient on _____.
This determination was completed on: _____.

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made:

_____ Your request for charity care has been approved for services rendered on _____.
After applying the charity care reduction, the amount owed is $_____.

_____ Your request for charity care is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____
_____
_____
_____
_____

_____ Your request for charity care has been denied because:

REASON: _____
_____
_____
_____

If you have any questions on this determination, please contact:

_____
Patient Services
Sutter Surgical Hospital – North Valley
(530) 749-5700

Sutter Surgical Hospital – North Valley
A Sutter Health Affiliate
With You. For Life.

CHARITY CARE CALCULATION WORKSHEET

Patient Name: _____ Patient Account #: _____
Affiliate: _____

Special Considerations/Circumstances: _____
_____
_____
_____

	Yes	No
Does Patient have Insurance?	☐	☐
Is Patient Eligible for Medicare?	☐	☐
Is Patient Eligible for Medi-Cal?	☐	☐
Is Patient Eligible for Other Government Programs (i.e. Crime Victims, etc.)?	☐	☐

If eligibility exists for above programs, patient will not generally be eligible for charity care.

Is Patient Self-Pay ☐ ☐

Charity/Financial Assistance Calculation:

Total Combined Current Monthly Income
(From Statement of Financial Condition) $_____

Family Size (From Statement of Financial Condition) _____

Qualification for Charity Care/Financial Assistance (circle one): Full Partial

(Identify using eligibility guide) Catastrophic No Eligibility

Partial Charity Write-off Calculation (complete this section only if patient qualifies for partial charity care):

A. Total Charges $_____
B. Medicare 120% Net Cost/Charge Ratio for Facility _____
C. Patient Liability (Line A *times* Line B) $_____
D. Discount Amount (Line A *minus* Line C) $_____

Catastrophic Charity Write-off Calculation (complete section only if patient qualifies for catastrophic charity w/o):

A. Patient Liability (total charges unless another discount has been supplied) $_____
B. Annual Income $_____
C. Patient Liability as Percent of Annual Income _____ %
D. Is Line A divided by Line B greater than .30 (30%)? Yes No
E. If no, patient is not eligible for this type of write-off. $0
F. If yes, multiply Line B by 30% to identify the patient liability amount $_____
G. If yes, Subtract line F from Line A to identify the write-off amount $_____

Total Amount of Recommended Charity Write-off(s): $_____

Worksheet Completed by: _____ Phone: _____

Approved by: _____
(see approval matrix)

AUTHORIZED FOR CHARITY WRITE-OFF

APPROVAL MATRIX: to be developed by each entity in accordance with departmental make-up, levels of management and size. For example:

CEO	Above	$10,000.00
CFO	Above	$1,000.00
Business Office Manager	Up to $	1,000.00

_____

Approval Signature(s)

_____

Date: _____

ATTACHMENT B: Sutter Health Federal Poverty Income Guidelines Sliding Scale

Eligibility Guide: Using household income and size as calculated in the Attachment A, identify elgibility for financial discount.

NATIONAL POVERTY INCOME GUIDELINES FOR 2011					
FAMILY SIZE	POVERTY GUIDE				Max Income per Month
1	$10,890	$13,613	$16,335	$21,780	$1,815
2	$14,710	$18,388	$22,065	$29,420	$2,451
3	$18,530	$23,163	$27,795	$37,060	$3,088
4	$22,530	$27,938	$33,525	$44,700	$3,725
5	$26,170	$32,713	$38,255	$52,340	$4,361
6	$29,990	$37,488	$44,985	$59,980	$4,998
7	$33,810	$42,263	$50,715	$67,620	$5,635
8	$37,630	$47,038	$56,445	$75,260	$6,271
9	$41,450	$51,813	$62,175	$82,900	$6,908
10	$45,270	$56,588	$67,905	$90,540	$7,545
EACH ADDITIONAL	$3,820	$4,775	$5,730	$7,640	
	100%	60%	40%	25%	
Source: Federal Register, Volume 76, Number 13, January 20, 2011, pp. 3637-3638					

Catastrophic Coverage:
If the Patient Liability is greater than or equal to 30% of the annual family income, amounts greater than 30% of the income may be written off to charity care due to catastrophic circumstances.